STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

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F0000	This visit was for Investigation of Complaints IN00106012, IN00106136, IN00106319 and IN00106628. Complaint IN00106012 Substantiated. Federal/State deficiencies related to the allegations are cited at F166 and F279. Complaint IN00106136 Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F323. Complaint IN00106319 Substantiated. Federal/State deficiencies related to the allegation is cited at F157. Complaint IN00106628 Substantiated. Federal/State deficiencies related to the allegation is cited at F205. Survey dates: April 12, 13 & 16, 2012 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Mary Jane G. Fischer ,RN Census bed type: SNF: 16	F0000	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after May 8, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 99 Residential: 12 Total: 127 Census payor type: Medicare: 18 Medicaid: 74 Other: 35 Total: 127 Sample: 5 Supplemental sample: 2 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 20, 2012 by Bev Faulkner, R.N.			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure a resident's physician was notified immediately for possible medical intervention when a resident fell from bed and sustained a	F0157	It is the practice of this facility to notify of changes (injury/decline/room, etc). **1. What corrective action(s) will be accomplished for those residents found to have been**	05/08/2012

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	head injury. This affected 1 of 3 residents reviewed for falls in the sample of 5. [Resident "C"]. Findings include: The record for Resident "C" was reviewed on 04-13-12 at 9:40 a.m. Diagnoses included but were not limited to dementia, cellulitis of the lower extremity, chronic kidney disease, dehydration and history of urinary tract infection. These diagnoses remained current at the time of the record review. The Resident Progress notes, dated 03-23-12 at 10:54 p.m., indicated "Resident noted lying on R [right] side on floor beside [resident] bed when staff responded to sounding PSA [personal safety alarm]. Resident states 'I fell out of bed.' Abrasions times 2 R forehead and nose. Bacitracin applied - left open to air. Vital signs and neuros [neurological checks] are stable. ROM [range of motion] to all extremities active without difficulty. Staff times 2 assisted to w/c [wheelchair]." Review of the Fall Event Report, dated 03-23-12, indicated the fall was "unwitnessed," the resident was "lying on the floor beside bed on R side - shoes off, and resident hit head, abrasions times 2 -		**affected by the deficient practice? The charge nurse performed a head to toe assessment on the resident immediately following the fall, including initiating neuro checks. First aid was administered to the abrasion on the resident's forehead and nose. All vital signs, including neuro checks were within normal limits. The attending physician was notified via fax at the time of incident, and returned an acknowledgement fax to the facility the next day. The resident was monitored per licensed nursing staff every shift for 72 hours, with no additional findings. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? All residents have the potential to be affected. The charge nurse was disciplined for failing to follow facility policy related to physician notification. All residents who experience a change of condition will have their physician notified. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The nursing staff was inserviced on April 20, 2012,**	

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	bacitracin, faxed [facsimile] MD [Medical Doctor] notification." The Emergency Department notations, dated 03-24-12 and reviewed on 04-12-12 at 11:00 a.m., indicated the resident "fell at Beech Grove Meadows and fell around 10 [p.m.] or 10:30 [p.m.] yesterday. Appears [resident] face planted, forehead bruising abrasions and nasal bruising and abrasion also had [sic] righ [sic] knee bruising." Review of the hospital History and Physical Notes, dated 03-25-12 on 04-12-12 at 11:00 a.m., indicated the following. "[Resident] was D/C [discharged] to the ECF [extended care facility] for rehab. [rehabilitation] recently from [name of local area hospital] on 03-11-12 for rehab. [Resident] fell over there on last Friday night and [family member] was called & informed about minor briuse [sic] on head. No further testing was done & when [family member] saw [resident] yesterday morning with a big bruise in [sic] [resident] head and felt that [resident] is not doing good. Mainly (R) [right] forehead large bruise +. [Resident] also have [sic] some small bruising around eyes." The facility policy titled, "Resident		**per the DNS Specialist, on appropriate physician notification protocol. The facility also adopted an expectation that the on-call nurse manager will be notified of all falls and will assist in implementing an immediate fall intervention and to ensure appropriate steps are taken for physician notification. All falls will be reviewed the following business day by the IDT for appropriateness of intervention to prevent future falls with or without injury, and the physician notification will be verified. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS or designee will perform a thorough audit, including physician notification, following every fall, using a fall CQI audit tool. This will be an ongoing procedure. Continued education/inservicing will be provided to the nursing staff to achieve 100% compliance. Disciplinary action will occur if the policy is not followed. 5. The facility alleges date of compliance on May 8, 2012**	

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	Change of Condition," dated as "revised" 3/2010, and reviewed on 04-16-12 at 9:30 a.m., indicated the following: "POLICY [bold type]: It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsibly party, and that appropriate, timely and effective intervention occurs." "Procedure 2. Acute Medical Change - a. Any sudden or serious change in a resident's condition manifested by marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician. During an interview on 04-16-12 at 2:00 p.m., the Director of Nurses indicated "The nurses should have called the Doctor. Sending a fax is not appropriate for a resident with a head injury." This Federal tag relates to complaint IN00106319. 3.1-5(a)(1)			

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F0166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on interview and record review, the facility failed to ensure prompt and continued resolution to a resident's concern, in that when a resident expressed a concern about not receiving the physician ordered supplement, the facility failed to ensure the nurses were educated in the exact supplement as ordered for 1 of 3 residents reviewed for supplements in a sample of 5. [Resident "A"]. Findings include: The record for Resident "A" was reviewed on 04-13-12 at 8:40 a.m. Diagnoses included but were not limited to obesity, insomnia, hypertension diabetes mellitus and recent bariatric surgery. These diagnoses remained current at the time of the record review. The resident's record included communication from the local area hospital "Bariatric Center," dated 01-04-12 and 04-04-12, which included dietary recommendations for "two Ensure high protein drinks daily."	F0166	It is the practice of this facility resolve grievances promptly. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The attending physician and MD specialist were notified of the error made by the nurse. The resident's weight has remained stable, and there have been no adverse effects from the resident consuming the regular Ensure vs. High Protein Ensure. The Executive Director, Director of Nursing Services Specialist, Social Services Director, Unit Manager and resident met on April 26, 2012 to go over her current physician orders and current plan of care. Resident's protein level will be monitored per physician order. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? All residents have the potential to be affected. The nurse management staff were inserviced on the correct**	05/08/2012

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	Review of the most recent signed physician re-write for April 2012 included an physician order for "Ensure High Protein Van [vanilla] 8 ounces - give 1 can by mouth twice daily 10:30 a.m. and HS [bedtime]." The facility "care and concern log" for the months of January 2012 thru April 2012, reviewed on 04-12-12 at 2:00 p.m., included documentation by Resident "A" on 01-08-12, 01-29-11 [sic] and 03-14-12 and included information as follows: "01-08-12 8:00 p.m. It is 8:00 p.m. and I still have not received my meds or 5 p.m. Ensure. I asked for them and the nurse refused to give them to me. This happens every weekend when [name of a specific nurse] isn't here." The Director of Nurses indicated review of this concern as dated 01-10-12 and a handwritten notation indicated "corrections made - nurse made error, counseling statement - med error given to nurse re: [regarding] job performance. Assured resident concern was addressed. Res. [resident] okay." The concern was signed by the Executive Director on 01-16-12. "01-29-11 9:00 p.m. [Registered Nurse employee #10] gave me Ensure Plus instead of Ensure HP [high protein] twice on Sunday." The Unit Manager		**procedure for reporting and following up on resident or family grievances. On April 18, 2012, an audit was performed on the grievances that have been received by the facility in the past 30 days. All were complete, with follow up and family/resident satisfaction. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Guest Relations Coordinator or designee will collect the grievance forms and distribute them to the appropriate Department Head. That Department Head or designee will investigate and follow up with the resident, family, staff or other persons involved in the grievance, and that information will be included in the response section of the form. The Department Head will investigate the grievance within 24 hours of receipt and will return to the Guest Relations Coordinator. The Guest Relations Coordinator will coordinate the process to ensure appropriate follow up occurs. The Guest Relations Coordinator will forward the grievance to the Executive Director. After the Executive Director has read and signed acknowledgement of receipt,**	

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	documented the "nurse was re-educated, disciplined." The Unit Manager further documented "spoke with [name of resident] stated that [resident] was really upset but said that nursing handled the issue in a timely manor <sic> and is okay now." The concern was signed by the Executive Director on 01-30-12. "03-14-12 6:30 p.m. I am not getting my Ensure since [Licensed Practical Nurse employee #11] started working "F" hall. She keeps bringing me Immunity boost and when I tell her I need High Protein she says OK but doesn't go get it." The Director of Nurses notation, dated 03-15-12, indicated the issue was discussed with the nurse, who indicated she "thought Ensure therapeutic was the same as Ensure High Protein. Res. has plenty of Ensure available. Discussion re: [illegible word] Res. okay with resolution." The concern was signed by the Executive Director on 03-26-12. Documentation provided by the Dietary Staff indicated that Ensure High Protein contained 12 grams of protein per serving, 230 calories and 31 total carbohydrates, while Ensure Plus contained 13 grams of protein, 350 calories and 51 carbohydrates. During an interview on 04-13-12 at 1:20		**the Guest Relations Coordinator will contact the resident and/or family to ensure satisfaction with the results of the investigation. Grievances will be completed within 72 hours of receipt. Grievances are discussed during the morning meeting with Department Heads. An inservice was held on April 20, 2012 for the nursing staff and Department Heads on the grievance process by the Director of Nursing Services Specialist. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Guest Relations Coordinator will maintain all grievance forms, and will audit them for accuracy, completion and satisfaction of the grievance using the ASC Grievance CQI tool once a week for 4 weeks, bi-monthly for two months, once a month for three months, then quarterly thereafter. If threshold of 95% is not met, an action plan will be developed. 5. The facility alleges date of compliance on May 8, 2012**	

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	p.m., the Resident indicated "everything is better now - the one nurse didn't know the difference between the two different Ensures [supplement], Plus and High Protein. I know I need the extra protein and I get worried if I'm going to get it." Interview on 04-16-12 at 9:30 a.m., the Director of Nurse indicated she counseled Registered Nurse employee #10 for the incident on 01-08-12 and Licensed Practical Nurse employee #11 for the incident on 03-14-12, but was unaware of the concern voiced by the resident on 01-29-12 which also involved Registered Nurse employee #10 . The Director of Nurses further indicated that although she notified the resident's primary physician she failed to notify the hospital Bariatric Center. Review of the facility policy on 04-13-12 at 9:00 a.m., titled "Resident Grievances and Concerns," dated as "revised 01-2006, indicated the following" "POLICY [bold type] It is the policy of this facility that resident or family grievances/concerns occurring during the resident's stay in the facility shall whenever possible, be responded to by the designated Social Service worker or responsible Department Head closest to the cause of the grievance/concern."			

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	"Regardless of which supervisor/department head responds, the Executive Director of his/her authorized representative shall review all complaints. Responses to resident/family shall be made as immediately as possible. Within 48 hours the problem should be resolved and each action documented. It should be noted that if the resident or resident's family continues to express a concern and in their view, the problem is not resolved, the Executive Director must be apprised of the situation and the Executive Director must keep the Director of Operations informed. Ongoing concerns or disenchantment with the services and/or resident care must be dealt with in a one-on-one fashion by the Executive Director." This Federal tag relates to complaint IN00106012. 3.1-7(a)(2)			

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F0205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. Based on record review and interview, the facility failed to ensure sufficient notification in regard to the facility bed hold policy, in that when a resident who was identified as a private pay resident was transferred to a local area hospital for evaluation and treatment, the facility staff failed to provide information to the resident's family member of the facility bed hold policy. This deficient practice effected 1 of 3 residents reviewed for transfer in a sample of 5 and 2 of 2 supplemental sampled residents. [Resident's "D", "F" and "G"].	F0205	It is the practice of this facility to notify residents of the bed-hold policy. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The resident's POA was refunded the monies charged for the bed during the resident's in-hospital stay by the Business Office Manager. The Bed-Hold Policy was given to and explained to the POA for future reference. 2. How will you identify other residents having the potential to be**	05/08/2012

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	Findings include: The record for Resident "D" was reviewed on 04-13-12 at 9:50 a.m. Diagnoses included but were not limited to presenile dementia, diabetes mellitus, anemia, hypertension and metastatic breast cancer. These diagnoses remained current at the time of the record review. During an interview on 04-13-12 at 1:00 p.m., the resident's family member indicated the resident had been transferred to [name of local area hospital] in March [2012], and even though the resident remained in the hospital for two days they were "charged" for the days [resident] wasn't in the building." During further interview, the family member indicated being unaware of a policy related to 'holding the bed' or 'paying for the bed' when [resident] was in the hospital." Interview on 04-13-12 at 1:30 p.m., the Business Office Manager employee #5 indicated she was unaware the resident had gone to the hospital until the family member brought it to her attention. "Once I found out about it a refund was made." The Business Office Manager provided a ledger where the resident's account was refunded the amount of $380.00 for the two days the resident was		**affected by these same deficient practice and what corrective action will be taken? All residents have the potential to be affected. If any residents were charged for a bed during an in-hospital stay and had not been informed of the Bed Hold Policy, their monies will be refunded. All residents who leave the facility to be seen by a medical professional or to be admitted to an alternative health care setting or being discharged to home will be given a copy of the Bed-Hold Policy upon discharge or LOA from the facility. A copy of the Bed Hold Policy will be maintained in the resident's chart. The nursing staff were inserviced on the facility Bed Hold Policy on May 2, 2012. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All residents who leave the facility to be seen by a medical professional or to be admitted to an alternative health care setting or being discharged to home will be given a copy of the Bed-Hold Policy upon discharge or LOA from the facility. A copy of the Bed Hold Policy will be maintained in the resident's chart. The electronic medical record lists**	

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	155072	A. BUILDING 00 B. WING	04/16/2012

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	in the hospital. When further interviewed on 04-16-12 at 2:15 p.m., the Business Office Manager indicated the refund was made after the first of April [2012]. "In the past I have notified the residents and family members about the bed hold policy, but I haven't done that since I returned to this position." When interviewed if other residents who were identified as private pay, had been transferred to the hospital, and provided appropriate documentation related to the facility bed hold policy, the Business Office Manager provided the names of two additional residents which included Resident's "F" and "G". The Business Office Manager indicated on 04-16-12 at 2:30 p.m., that Resident "F" went to the hospital for two days; 11-29-11 thru 12-01-11, and Resident "G" went to the hospital for 5 days; 03-19-12 thru 03-24-12. The Business Office Manager indicated she was unable to find documentation related to notification of the facility bed hold policy. Review of the Resident Handbook, Resident Rights and Advanced Directive book on 04-12-12 at 1:30 p.m., indicated the following: "ADMISSION, TRANSFER AND DISCHARGE RIGHTS"		**the documents required to send with the resident upon discharge. The nurse will check the appropriate box for the Bed Hold Policy. The nursing staff were inserviced on the facility Bed Hold Policy on May 2, 2012 by the Director of Nursing Services Specialist.** **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **The DNS or designee will perform an audit of all discharged residents' charts the next business day using the Hospital Discharge Transfer CQI audit tool to confirm the presence of a copy of the Bed Hold Policy in the chart. If no copy is present, the facility will send a copy via certified U.S. Mail to the POA. This audit will be ongoing.** **The facility alleges date of compliance on May 8, 2012**	

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"(b) Notice of Bed-hold policy and readmission. (1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave of twenty-four (24) hours duration or longer, the facility must provide written information to the resident and a family member or legal representative that specifies - (i) The duration of the bed-hold policy under the Medicaid state plan during which the resident is permitted to return and resume residency in the facility. (ii) The facility's policies regarding bed-hold periods which must be consistent with subdivision (3), permitting a resident to return."

"(2) Notice upon transfer. Except in an emergency, at the time of transfer of a resident for hospitalization or therapeutic leave, a facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in subdivision (b)(1)."

Review of the Admission packet on 04-12-12 at 1:30 p.m., the facility Bed Hold policy indicated the following:

"In the event a resident leaves the facility for a temporary stay in an acute care

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	hospital or elsewhere for a therapeutic leave that exceeds midnight the day they leave, the resident or resident's responsible party may request the facility to hold open the residents bed during their absence by paying the full daily rate. A facility representative will contact the responsible party and/or POA [power of attorney] to obtain their wishes on whether they prefer to have the resident discharged or whether they would like to pay the daily rate during their absence to hold the bed." This Federal tag relates to IN00106628. 3.1-12(a)(25)(B)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, the facility failed to develop comprehensive care plans which included measurable objectives based on resident needs for 2 of 5 sampled resident's. [Resident's "A" and "B"]. Findings include: 1. The record for Resident "A" was reviewed on 04-13-12 at 8:40 a.m. Diagnoses included but were not limited to obesity, insomnia, hypertension diabetes mellitus and recent bariatric	F0279	It is the practice of this facility to develop comprehensive care plans. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents A and B care plans were reviewed and updated according to their current medical diagnoses. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? All residents have the potential**	05/08/2012

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	surgery. These diagnoses remained current at the time of the record review. The resident's record included communication from the local area hospital "Bariatric Center," dated 01-04-12 and 04-04-12, which included dietary recommendations for "two Ensure high protein drinks daily." Review of the most recent signed physician re-write for April 2012 included an physician order for "Ensure High Protein Van [vanilla] 8 ounces - give 1 can by mouth twice daily 10:30 a.m. and HS [bedtime]." The resident's record lacked a plan of care related to the need for additional protein in the resident's diet. 2. The record for Resident "B" was reviewed on 04-13-12 at 1:00 p.m. Diagnoses included but not limited to dementia, dehydration, diabetes mellitus, cerebral vascular accident and gout. These diagnoses remained current at the time of the record review. The record indicated the resident returned to the facility on 03-22-12 after a recent hospitalization at which time the resident was identified with dehydration.		**to be affected. All residents' hydration assessments were evaluated on April 27, 2012 to determine their hydration risk. Those residents found to be at risk were placed on a 3 day hydration monitoring system. Each residents' total fluid intake will be evaluated and individual hydration plans will be implemented accordingly. Their care plans will be written to match their hydration needs/assessment/actual intake. All residents are reviewed in IDT on a quarterly basis or as needed and care plans are updated to reflect their current care needs related to their physicians' orders and diagnoses. The nurse management team was inserviced on April 26, 2012 by the Director of Nursing Services Specialist. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All residents who are admitted, re-admitted, have a significant change in status, and/or are scheduled for a quarterly or annual MDS assessment will be reviewed and their care plans updated accordingly. Every resident's care plan for hydration/dietary needs will be reviewed and their current daily fluid needs**	

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	Review of the resident's most recent plan of care, originally dated 09-30-11, indicated the resident was at risk for fluid imbalance related to congestive heart failure and diuretic medication use. Interventions to this plan of care indicated/included "will remain free from dehydration or fluid overload, hydration assessment, observe fluid intake and observe for signs and symptoms of dehydration fluid overload dry pale mucous membranes skin tenting, decreased urinary output shortness of breath, dyspnea or increase enema." A subsequent plan of care, dated 12-22-10, indicated the resident was on a therapeutic diet related to diagnoses of diabetes mellitus. Interventions to this plan of care instructed the nurses to "monitor po [by mouth] and fluid intakes." During an interview on 04-16-12 at 2:25 p.m., the Director of Nurses indicated when the resident returned from the hospital the nursing staff was supposed to complete a 3 day "Hydration Management" assessment in which there was 3 days of fluid intake recorded. The Director of Nurses indicated the assessment could not be located in the resident's record; however, the dietician indicated the resident required 1900 ml		**will be added as a goal. Any residents who receive dietary supplements will have their care plan address their specific supplement to be received. The nurse management team was inserviced on April 26, 2012 by the Director of Nursing Services Specialist. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS or designee will perform an audit of the Care Plan Program using the Care Plan Updating CQI audit tool and the Hydration Program using the Hydration Management CQI audit tool once a week for four weeks, biweekly for two months, monthly for three months and quarterly thereafter. If the threshold of 95% is not met, an action plan will be developed. 5. The facility alleges date of compliance on May 8, 2012**	

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	[milliliters] - 2280 mls of fluid per day. Further review of the "Hydration Management" policy indicated that once the assessment was completed a comprehensive care plan would be written. The current plan of care lacked the specific measurable information related to the resident's hydration needs. This Federal tag relates to complaint IN00106012 and IN00106136. 3.1-35(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident was free from accidents; in that when a resident was unable self transfer from the wheelchair, the nursing staff failed to provide supervision after an assisted transfer, and also failed to ensure the resident received the needed assistive devices to alert the staff of unassisted transfer for 1 of 3 residents reviewed for falls in a sample of 5. [Resident "B"]. Findings include: The record for Resident "B" was reviewed on 04-13-12 at 1:00 p.m. Diagnoses included but not limited to dementia, dehydration, diabetes mellitus, cerebral vascular accident and gout. These diagnoses remained current at the time of the record review. Review of the resident's Minimum Data Set assessment [MDS], dated 03-02-12, indicated the resident required extensive assistance and one staff member while toileting and was unable to move off the	F0323	It is the practice of this facility to be free of accident hazards/supervision/ devices **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The resident's fall risk assessment was completed on April 16, 2012, which shows her at risk for falls. A physician order for personal safety alarms to bed and chair was received on 4/16/12. After further assessment, it was determined that the resident would benefit from a pull tab alarm in chair to prevent accidental fall from wheelchair due to resident leaning forward while sitting. A physician order was received for the pull tab alarm and to discontinue the pressure alarm to the wheelchair on April 24, 2012. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? All residents have the potential to be affected. An inservice will be held on May 8,**	05/08/2012

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	toilet, but only able to stabilize with the assistance of a staff member. A review of the facility event report, dated 03-16-12 at 7:55 p.m., indicated the resident had a "witnessed fall while transferring from wheelchair to toilet. Resident was laying left lateral recumbent upon the bathroom floor and the resident indicated 'it hurts a lot to move my legs.' The report further indicated the resident received a 3 centimeter skin tear at resident's left forearm. The resident was "attempting to transfer from wheelchair to toilet without success became 'too weak' to continue, assisted to the floor by CNA [Certified Nurses Aide]. As CNA moved to the doorway to call out for assistance, resident fell backwards from a seated position onto the floor. Resident complained of pain upon movement of legs. Ambulance service called for and arrived immediately, being very nearby. Resident packaged [sic] et [and] out to hospital [name of local area hospital] before VS [vital signs] assessment was started." The report questioned "What intervention(s) was put into place to prevent another fall?" The response was "when resident returns from the hospital we can use PSA [personal safety alarm] to wheelchair and bed at all times check for placement and function each shift."		**2012 for all departments related to fall/accident prevention, policies and procedures by the Director of Nursing Services Specialist. Residents who have fallen will not be left alone at any time after the incident until assessment for injury by a licensed nurse has been completed. An audit will be performed to ensure alarms are present per physician order. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Charge nurse will monitor the function and placement of each physician ordered safety alarm every shift. Each fall is reviewed by the IDT on the business day following the incident. All actions by the staff will be reviewed for appropriateness. Education and/or discipline will be given to the staff on an as needed basis. An inservice will be held on May 8, 2012 for all departments related to fall/accident prevention, policies and procedures by the Director of Nursing Services Specialist. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	During an interview on 04-16-12 at 2:00 p.m., the Director of Nurses indicated the Certified Nurses Aide should have stayed with the resident and used the emergency bathroom call light to obtain help with the resident. The record indicated the resident returned to the facility on 03-22-12. Review of a subsequent "event report," dated 04-11-12 at 10:15 p.m., indicated the following: "Resident was transferring self from w/c [wheelchair] unto bed without assistance. Assigned aide was walking down the hallway and fortunately happened to have looked into resident's room to observe resident transferring self unassisted and was at risk of falling. Assigned aide stated she then asked a second aide who was with her at the time to help sit resident in bed. Resident was far away from bed and they [sic] best they could to [sic] for the resident at the time was gently lower resident to the floor." The section of the event report which prompted the nurse in regard to interventions indicated "Resident sent out to ER [emergency room] for further eval. Upon return, resident is to have PAB [personal bed alarm] and PAC [personal chair alarm] nursing to check for placement and function q shift...."		**The DNS or designee will perform a thorough audit, including presence of safety devices, following every fall, using a fall CQI audit tool. This will be an ongoing procedure. Continued education/inservicing will be provided to the nursing staff to achieve 100% compliance. Disciplinary action will occur if the policy is not followed. The facility alleges date of compliance on May 8, 2012**	

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	During an interview on 04-13-12 at 12:30 p.m., a concerned family member indicated the resident was supposed to have the alarm attached after the fall in March [2012], and questioned why the alarm didn't activate when the resident started to rise from the chair. During an interview on 04-16-12 at 9:15 a.m., the Director of Nurses indicated that upon review of the March 2012 Medication Record an "unidentified nurse discontinued the alarm system and documented on the Medication Record that the alarm was "not appropriate at present - compliant with call light." "Once the nurse wrote that statement on the March [2012] Medication Record the information about any type of alarm was not transferred to the April [2012] Medication Record. The nurses didn't know about it." This Federal tag relates to complaint IN00106136. 3.1-45(a)(2)			